Committee of Interns and Residents
SEIUHealthcare

HOUSE STAFF BENEFITS PLAN
520 EIGHTH AVENUE, SUITE 1200 NEW YORK, NY 10018-4181

Phone: (212)-356-8180 **Fax: (212)-356 – 8181** **benefits@cirseiu.org** **www.cirseiu.org**

OUT OF NETWORK
HEARING AID REIMBURSEMENT FORM

Eligibility**:** HSBP employees including eligible dependents.

Maximum reimbursement allowed: A lifetime maximum reimbursement of $5,000 per ear to cover the cost of a hearing aid. In no way will the reimbursement be more than what was paid out of pocket.

Claim Submission Rules:

- Entire Claim form must be completed in full by participant, patient or parent, if minor.
- A separate claim form must be submitted per patient.
- The need for a hearing aid must be approved by a certified audiologist and a letter from the audiologist a letter from the audiologist must be submitted with the original bill.
- The bill must state the provider's name, address and phone number, patient's name and address, services rendered, date of service and amount of purchase.
- Claims must be submitted to our office via fax or mail (contact info in letterhead) within one year from date of purchase. Please do not email claims. The Plan reserves the right to request original receipts.

Please complete the following:

Participant's Name: _____ _____
(Last Name) (First Name)

Social Security No.: _____ Hospital where employed: _____

Home Address: _____

_____ _____ _____
(City) (State) (Zip code)

Contact phone number: _____ Type (home, mobile, etc.) _____

E-mail address: _____

Patient's Name: _____ _____
(Last Name) (First Name)

Relationship to participant: _____

Patient's Signature or parent, if minor: _____ Date: _____

(06/15)